STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335449	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Achieve Rehab and Nursing Facility	170 Lake Street Liberty, NY 12754

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49255 Based on observation, interview and record review conducted during recertification and abbreviated (NY 00351312) surveys from 10/16/24 to 10/23/24, the facility did not ensure action as a fiduciary (trustee) of the resident's funds and hold, safeguard, manage, and account for the residents' personal funds deposited with the facility for 1 (Resident #14) of 1 resident reviewed for personal funds. Specifically, the facility did not ensure residents had access to their personal funds on weekends. The findings are: Review of an undated facility policy and procedure titled Resident Personal Needs Account Policy documented that residents have the right to manage their own personal funds. The facility assists with holding, safeguarding, managing, and accounting for their personal funds. The personal needs account will be accessible daily including weekends and holidays as residents see fit. Resident banking is typically conducted through the front desk from 7 am to 9:30pm, 7 days a week. Review of the facility policy titled Resident Rights revised December 2016 documented federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to manage their personal funds, or have the facility manage their funds if they wish. The Reception Bank Log records revealed the beginning balance was 0 from 7/3/24 to 7/8/24, and from 7/9/24 to 7/10/24. The Reception Bank Log records revealed August had some days/dates with missed documentation. During the Resident Council Facility Task meeting on 10/17/24 at 10:46 AM, the President of Resident Council Resident #14 stated the money was down at the desk, and by 7 or 8 PM the money set aside at the desk was all gone. Resident #14 discussed with administration the subject of the facility getting an ATM. Resident #14 stated the staff at the desk had a list of residents with money and they would fill out a slip and withdraw money. They said this list was not always up to date. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/24 at 10:38 AM with Resident #14. They stated two weekends ago they requested $20 from the reception desk bank box, and the receptionist said there was no money at all. Resident #14 stated they have enough money in their bank account. Resident #14 stated the facility has the list of residents with personal funds and balances they have. Resident #14 stated there was no plan in place when the facility reception desk bank box runs out of money. They stated on Fridays many residents take money to buy food, and on weekends often there was no money. Resident #14 stated if they requested a check, they had to wait ten days to get that check processed. The Personal Fund Statements revealed Resident #14 had a personal funds account with the facility. The October 2024 Reception Bank Log record revealed 10/11/24 and 10/13/24 days were not documented in the log. On Saturday 10/12/24 the Beginning Balance was 0. During an interview on 10/21/24 at 10:53 AM the Receptionist stated they have a desk bank box where they have personal funds for the residents. The Reception Bank Log sheets were updated every day. The Receptionist stated in this bank box also included envelopes with cash from residents' families. They stated residents have easy access to their funds. From Monday to Friday the Business Office Manager controls the amount of money placed in the bank box. The Receptionist stated that total amount of money can vary, but on weekends the facility always has at least the minimum of $100 in the bank box. The residents could get a maximum limit of $50 per day. They stated residents knew that Business Office Manager was not working on weekends, and they all tried to take money between Monday and Friday. But if on weekends the requested amount of money exceeded the amount of money in the bank box, the receptionist would call the Business Office Manager and they bring money. The Receptionist could not explain why the Reception Bank Logs documentation reflected 0 on some days and also had missed dates. During an interview on 10/21/24 at 11:43 AM the Social Worker Assistant stated they were not aware about any issues with residents access to their funds. During an interview on 10/21/24 at 11:50 AM the Business Office Manager stated they started working in this role in May 2024. They monitor residents' funds and the amount of money the residents have on their accounts constantly updating the list of the residents and the reception bank box, and providing residents access to their funds as soon as possible. Every month they received petty cash from the bank and placed some amount of money to the bank box and some amount of money was kept at their office. The Business Office Manager stated on Fridays they ask the receptionist if there is enough [NAME] for the weekend. They stated if any issues took place the receptionist would call them, and they would come to the facility and replenish the bank box with money. The Business Office Manager stated they were not aware of situations when there was not enough money for the residents on weekends. The Business Office Manager could not state why the Reception Bank Log had a0 balance on certain days, discrepancies and missing days in the documentation. 10 NYCRR 415.3(g)(1)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 48847 Based on record review, and interview conducted during the recertification and abbreviated surveys (NY 00326169) from 10/16/24 to 10/23/24, the facility did not ensure that the Minimum Data Set assessments accurately reflected the residents' status at the time of the assessments for 1 (Resident #280) of 35 sampled residents. Specifically, the Minimum Data Set assessment inaccurately documented that Resident #280 who had a care plan for bed and chair alarms, was assessed to have no alarms. The findings are: Resident #280 was admitted with diagnoses including but not limited to a displaced intertrochanteric fracture of the right femur, history of falling, and muscle weakness. The 8/2/23 At Risk For Falls Due To An Adjustment To A New Environment Care Plan documented interventions including placing alarms to both the bed and the chair. The 8/5/23 Admission Minimum Data Set documented Resident #280 had intact cognition and had no bed or chair alarms. During an interview on 10/22/24 at 3:28 PM, the Minimum Data Set Coordinator stated that when they are doing the Minimum Data Set, they will look at the Care Plans for information but sometimes they are too lengthy. They stated if a Care Plan indicated a resident was receiving a bed or chair alarm, it should have been captured on the Minimum Data Set and they did not code it on the Minimum Data Set. 10NYCRR 415.11 (b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43478 Based on observation, record review, and interview during the recertification and abbreviated (NY 00322762) surveys conducted 10/16/24 to 10/23/24, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, and nursing, needs for 1 of 3 residents (Resident #84) reviewed for hospitalization s, 2 of 2 residents (Residents #122 and #72) reviewed for urinary tract infections, 2 of 3 resident (Residents #179 and #98) reviewed for respiratory care, and 1 of 6 residents (Residents #281) reviewed for accidents. Specifically, 1.) Resident #84 did not have a care plan in place to address cardiac issues, 2.) Resident #122 did not have a plan of care in place to address urinary tract infection or cystitis (inflammation/infection of the bladder), and 3.) Resident #179 did not have a care plan in place to address respiratory care and the use of oxygen. The findings are: The facility policy, Care Plan revised 7/2020, documented that each resident will have an individualized interdisciplinary plan of care in place. The procedure documented the Interdisciplinary team will develop and implement the Comprehensive Care Plan within 21 days of admission, and each discipline will be responsible for the initiation and ongoing follow-up for care plans as related to their area of expertise. 1. Resident #84 was admitted with diagnoses including but not limited to Hypertension, Atrial Fibrillation, and Heart Failure. The 7/6/24 Quarterly Minimum Data Set documented Resident #84 was taking an anticoagulant (blood thinner) medication. The Physician's orders documented 9/27/24 Metoprolol Tartrate 25 mg tablet, give 12.5 mg every 12 hours for hypertension and 9/28/24 Apixaban 2.5 mg twice a day for Atrial Fibrillation, There was no documented evidence in the electronic medical record that a care plan was developed to address cardiac issues. On 10/21/24 at 2:50 PM during a review of Resident #84's care plan with Registered Nurse #9, no cardiac care plan could be located. Registered Nurse #9 stated there should be a cardiac care plan in place. Registered Nurse #9 stated the Admission Nurse and the Unit Manager were responsible for writing the care plans. 2. Resident #122 was admitted with diagnoses including but not limited to urinary tract infection, renal insufficiency, and benign prostatic hyperplasia. The 8/22/24 Nurse's Admission Note documented diagnoses included renal incident sepsis, urinary tract infection, presence of urinary catheter, amber urine. Reported to Director of Nursing to review admission/orders with covering provider. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician's orders documented 8/22/24 Amoxicillin-Potassium Clavulanate (Augmentin) (antibiotic) oral tablet 875-125 mg every 12 hours for urinary tract infection completed 8/27/24 The 8/23/24 Nurse Practitioner Note documented diagnoses included sepsis secondary to cystitis. The Assessment/Plan included continue antibiotic Augmentin. The 8/26/24 Physician Note documented diagnoses included sepsis secondary to cystitis. The Assessment/Plan included to continue Augmentin. The 8/26/24 Admission Minimum Data Set documented Resident #122 was taking antibiotic medication. The 10/7/24 Physician Note documented resident is status post catheter change and has had foul smelling urine. Urinalysis requested & granted. The 10/14/24 Physician's Order documented Zosyn intravenous solution 3-0.375 GM/50 ML (Piperacillin Sodium-Tazobactam Sodium in Dextrose) (antibiotic) intravenously every 8 hours for cystitis for 7 days completed 10/21/24. There was no documented evidence in the electronic medical record that a care plan was developed to address urinary tract infection or cystitis The 10/14/24 Nurse Practitioner Note documented urinalysis with significant sediment in urine and malaise for 3 days. Urine culture positive for proteus mirabilis, report of pain in stomach & back. Start Zosyn 3.375 every 8 hours for 7 days. On 10/22/24 at 9:50 AM during a review of the resident's care plan with Registered Nurse #10, they stated the nurse who admitted the resident and the Unit Manager and Nursing Supervisors were responsible to write care plans. On 10/22/24 at 9:52 AM during a review of the resident's care plan with the Director of Nursing, there was no documented evidence of a care plan for Resident #122's urinary tract infection. The Director of Nursing stated the nurse who admitted the resident and the Unit Manager and Nursing Supervisors were responsible to write care plans. 3. Resident #179 was admitted to the facility with diagnoses including Asthma, Obstructive Sleep Apnea, and Anxiety. The 9/26/24 Admission Minimum Data Set documented Resident #179 had intact cognition and was receiving oxygen. The 9/19/24 Physician Order documented oxygen 4 liters/minute via nasal cannula continuously. The 9/19/24 Physician Order documented oxygen tubing and bottle change weekly and as needed. The 9/26/24 at 6:54 PM, Nursing Progress Note documented resident was not able to lay flat in bed related to shortness of breath and remains on oxygen at 4 liters/minute via nasal cannula continuously. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/5/24 at 21:32, Nursing Progress Note documented resident awake, alert, and oriented and receiving oxygen. There was no documented evidence in the electronic medical record that a care plan was developed to address oxygen use. On 10/23/24 at 1:25 PM, during an interview, the Director of Nursing stated on admission the resident's care plan should be initiated and should be followed up by the unit managers and nursing supervisors. The Director of Nursing stated the checklist should be reviewed for all new admissions, to ensure the care plans are in place for newly admitted residents. 10 NYCRR 415.11 49364 45478 49255 48847

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observation, record review, and interview conducted during the Recertification and Abbreviated Surveys (NY 00326169, NY 00341314, and NY 00322762) from 10/16/24 to 10/23/24, the facility failed to ensure the residents' environment remained as free of accidents hazards as possible for 3 (Residents #280, #281 and #92) of 6 residents reviewed for accidents. Specifically, 1. Resident #280 was assessed at high risk for falls, care plan interventions were not in place and Resident #280 had an unwitnessed fall and required hospitalization for two lacerations to the face and a subdural hematoma (brain bleed). The facility did not thoroughly investigate to determine if interventions were adequate, and if the plan of care was followed. 2. Resident #281 was eating dinner, became unresponsive, required cardiopulmonary resuscitation and was sent to the Emergency Department. The facility did not investigate the incident to determine if the resident received the correct food consistency, had adequate supervision, or choked during the meal. 3. Resident #92 required two staff assistance and the use of a mechanical lift and was transferred by Certified Nurse Aide #13 without the use of a mechanical lift or other staff, and sustained a broken wrist. The findings are: The facility policy titled Safety Alarms last revised on 7/2023 documented that the nurse placing the safety alarm will place the alarm on the Medication Administration Record, to be checked every shift, specifying the site and whether the alarm is functioning properly. The Registered Nurse Manager or Registered Nurse Supervisor will then place the information in care tracker. The facility policy titled Accident/Incident Report last revised on 09/2023 documented the facility is responsive to investigate Incidents/Accidents in order to determine possible causative factors and implement interventions that may prevent a reoccurrence of the same or similar event. The Investigative Report appropriate to the type of Incident/Accident will be initiated and completed in the electronic medical record by the Licensed Nurse, Registered Nurse Manager, or the Nursing Supervisor following each Incident/Accident 1. Resident #280 was admitted to the facility with diagnoses including displaced intertrochanteric fracture of the right femur (broken hip), history of falls, and muscle weakness. The 8/2/23 Physician's Order documented safety checks to be done every hour for 24 hours. The 8/2/23 At Risk for Falls Care Plan documented the goals were to minimize the risk for injury related to falls, and to have no injury requiring transfer to the hospital. Interventions included place an alarm to both the bed and chair and check for placement and function every shift, bed to be in the lowest position, encourage to transfer and change positions slowly, encourage to use assistive devices for ambulation/transfer. Review of the August 2023 and September Certified Nurse Aide Documentation Survey Reports, Medication Administration Records and Treatment Administration Records revealed no documentation of the interventions on the Falls Care Plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 8/3/23 Fall Risk Assessment documented Resident #280 was at high risk for falls. The 8/5/23 Admission Minimum Data Set documented Resident #280 had intact cognition, required extensive assist of two for bed mobility/transfers, extensive assist of one for toileting. The Minimum Data Set did not document the use of bed or chair alarms, as on the care plan of 8/2/23. The 8/14/23 at 10:22 PM Physical Therapist progress note documented Resident #280's roommate notified them that Resident #280 was standing up and going to the bathroom twice during the evening on Friday and Saturday. Resident #280 was not cleared to perform walking in room without supervision/limited assist. The 8/31/23 at 9:44 AM, Nurse Practitioner's note documented the resident was in therapy and became very weak and shaky. Physical Therapy reported the resident was having much difficulty standing with assistance. The assessment was weakness, altered mental status, and hypertension; the plan was to continue to monitor and ensure fall precautions were in place. Resident #280's Kardex (instructions for direct care staff), dated 9/4/23 documented bed in lowest position, alarm to bed, check placement & function every shift, and required a one-person extensive assist for toileting. The 9/4/23 at 8:11 AM Incident Report completed by former Director of Nursing #12, documented Resident #280 fell out of bed trying to get to the bathroom. Resident #280 was laying on their left side, with their glasses on which caused two lacerations to the left side of their face. Nonskid socks were in place. Resident #280 was alert with confusion as normal, no complaints of pain, vital signs within normal limits. The resident verbalized they were trying to get to bathroom. A box was checked that the resident was taken to the hospital. The Incident Report did not document the physician was notified. The 9/4/23 at 8:29 AM Nursing Progress Note, (linked to the incident report) by the former Registered Nurse Supervisor #2, documented on 9/4/23 they were called to the unit and Resident #280 was on the floor. Resident #280 stated they were attempting to go to the bathroom. The resident was lying on their left side, head by the door, feet toward the bed and wearing glasses which caused 2 lacerations to her left eye. The floor was dry, they were wearing non-skid socks, call bell was within reach. The resident was unsoiled and assisted to bed. Immediate interventions included assessed for pain/range of motion and injury; assisted off the floor with safety maintained, vital signs obtained and stable. The resident was educated on the need to use the call bell for assistance. The 9/4/23 Certified Nurse Aide #30's Employee Statement documented they worked the 11 PM to 7 AM shift and were assigned to the resident at the time of incident, and the incident was at 7:00 AM. They documented they last saw the resident at 6:45 AM, the resident was in the bed, the resident was toileted and provided incontinent care at 6:45 AM. The resident had a low bed, but it was not in place at the time of the incident and the alarms were not sounding at the time of the incident. The 9/4/23 Certified Nurse Aide #29's Employee Statement documented they worked the 11 PM to 7 AM shift and the time of the incident was documented as 6. The last time they last saw the resident was 4 AM. They were not assigned to the resident and documented the resident did not have a low bed or alarms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician phone order dated 9/4/24, documented 30-minute neuro checks and 30-minute safety checks for 1 day for unwitnessed fall. There were no progress notes between 8:29 AM and 2:36 PM on 9/4/24 indicating the resident had left the facility. The 9/4/23 at 2:36 PM nursing progress note documented the facility contacted the Emergency Department at the local hospital and they were told the resident was transferred to another hospital with a diagnosis of subdural bleed (brain bleed). During an interview on 10/23/24 at 12:47 PM, Certified Nurse Aide #31 stated they did not document if residents had a low bed and that the toileting schedule did not pop up to toilet the resident every 2 hours, only to sign off for the entire shift. During an interview on 10/23/24 at 1:53 PM, the Director of Nursing stated if a resident was assessed at high risk for falls and was frequently or occasionally incontinent, they should be placed on every two-hour toileting schedule. The schedule should be on the Kardex for every two hours and the Certified Nurse Aides should be signing. The Director of Nursing stated the 9/4/23 Incident Report was not thorough and had discrepancies. The person completing the report should have made sure the report was thorough and complete. The Director of Nursing stated there were discrepancies in the time of the incident on the Incident Report that should have been further investigated. The facility was unable to provide any further evidence showing the incident had been thoroughly investigated. 2. Resident #281 was admitted on [DATE] with diagnoses including dementia, encephalopathy, and gastroesophageal reflux disease. A physician order dated 2/20/24 documented regular diet pureed texture with honey thick consistency; and Speech Therapy to evaluate and treat as indicated. The 2/24/24 Admission Minimum Data Set documented that Resident #281 had severely impaired cognition, required supervision with eating, coughed or choked during meals or when swallowing medications, had complaints of difficulty or pain when swallowing, and was on a mechanically altered diet. The Speech Therapy evaluation dated 2/21/24 documented Resident #281 was admitted to the facility on a regular diet with pureed consistency solids and honey thick liquids. The resident was unable to follow direction, had no teeth and dentures were not in place, and had mildly delayed swallow initiation with both honey thick liquids and nectar thick liquids. The resident appeared impulsive when self-feeding, taking large sips when consuming liquids. The speech therapist's recommendations included continuing puree solids and honey thick liquids, medication crushed in puree, upright positioning during and 30 minutes after meals, small bites/sips, slow pacing, and follow-up with speech therapy. The Speech Therapist progress note dated 2/25/24 at 2:03 PM documented recommendation for Resident #281 to upgrade to nectar thick liquids. The Speech Therapist progress note dated 3/13/24 at 1:01 PM documented recommendation to upgrade Resident #281's diet to mechanical soft solids and nectar thick liquids. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Speech Therapist progress note dated 3/19/24 at 3:26 PM documented Resident #281 had been successfully trialed on thin liquids with no observable signs or symptoms of aspiration. The recommendation was to upgrade to thin liquids, nursing staff was verbally notified. The 3/19/24 Physician order documented Resident #281 was on a regular mechanical soft texture diet, regular(thin) consistency liquids. The 3/21/24 at 7:42 PM Nursing Progress Note by Registered Nurse #25 documented that at approximately 5:50 PM they were called by the Certified Nurse Aide, and that upon assessment Resident #281 was cyanotic and non-responsive to verbal cues or palpation stimulation. A non-re-breathable mask was placed, and cardiopulmonary resuscitation was initiated. Resident #281 was sent out to the hospital. The 3/21/24 at 10:22 PM Nursing Progress Note by Registered Nurse Supervisor #16 documented they called for a report on Resident #281, and Resident #281 was being sent out to another hospital for evaluation of anoxic brain injury. The 3/21/24 Emergency Department report documented Resident #281 presented to Hospital #1 Emergency Department for cardiac arrest at home. Resident reportedly was choking during dinner when they arrested, cardiopulmonary resuscitation was done for a total of approximately twenty minutes. Resident #281 was intubated in the field with a 6.5 tube, and the Emergency Medical Services stated there was some resistance during intubation, and they believe they pushed a food bolus down. Resident was transferred to the Emergency Department at Hospital #2. The 3/22/24 Emergency Department report documented Resident #281 was treated for aspiration pneumonia with the antibiotic Zosyn and had the following diagnoses of cardiac arrest most like secondary to respiratory failure from choking, acute hypoxic respiratory failure secondary to choking events-aspiration pneumonitis, and food aspiration. During an interview on 10/21/24 at 5:03 PM, the Administrator stated they did not complete an Incident Report or investigation because they had staff statements that did not report Resident #281 was choking. The Administrator also stated when they received the hospital Emergency Department report, the report stated the diagnosis was cardiac arrest and not choking. During an interview on 10/22/24 at 11:28 AM, Speech Language Pathologist #2 stated if a resident became unresponsive during mealtime and cardiopulmonary resuscitation had to be initiated, the resident's meal ticket should have been saved. The staff should have checked to see if the resident received the right diet, and a referral should be sent to speech therapy to assess the resident for appropriate diet. During an interview on 10/22/24 at 12:36 PM, Registered Nurse #25 stated prior to Resident #281 becoming unresponsive, they were eating dinner at the nurses' station. They stated they were informed by the certified nurse aide that Resident #281 was choking and became unresponsive. They stated they gave the resident oxygen and transferred them to bed to start cardiopulmonary resuscitation and called 911. Registered Nurse #25 stated they did everything, including suctioning the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 12:53 PM, Certified Nurse Aide #24 stated Resident #281 was in the hallway by the nurses' station eating dinner when the nurse instructed them to page rapid response or 911, and they called 911. Certified Nurse Aide #24 stated the nurse started performing the Heimlich Maneuver and Resident #281 was turning blue. While on the phone with 911, the nurses took the resident into their room. Certified Nurse Aide #24 stated the nurses reported they were in the room for a long time doing cardiopulmonary resuscitation. Certified Nurse Aide #24 stated there was talk that there was a possibility of choking. During an interview on 10/22/24 at 04:37 PM, the former Director of Nursing stated that although Resident #281 became unresponsive while eating dinner, an Incident Report was not done because the Nursing Supervisor that called them and stated that Resident #281 received the correct food consistency. During an interview on 10/23/24 at 12:54 PM, the Director of Nursing stated that if a resident became unresponsive at mealtime, staff would check to see if the resident had food in their mouth and perform the Heimlich Maneuver. The Director of Nursing stated they would expect the nurses to document the food consistency served, how much they ate and if they had food in their mouth. The Director of Nursing stated when the facility called the Emergency Department to follow up on Resident #281, and it was reported the resident had a choking incident by the Emergency Medical Service Assessment, Incident Report and investigation should have been initiated by the facility staff. During an interview on 10/23/24 at 1:38 PM, [NAME] #2 stated they were on the unit when the nursing staff stated the resident was choking. [NAME] #2 stated that a nursing staff went behind Resident #281 while they were sitting at the nurses' station and started doing the Heimlich maneuver and it was not working. [NAME] #2 stated that it was during mealtime and resident had their tray in front of them. [NAME] #2 stated Human Resources questioned them about the incident but did not ask them to write a statement. During an interview on 10/23/24 3:42 PM, the Physician stated that if a resident was eating and became unresponsive, they would initiate a cardiopulmonary protocol, and after completion, the nurse would be expected to assess if the resident ate something that that they should not have. The Physician stated that if the Heimlich Maneuver was initiated, then the resident's airway had to be blocked, and that an investigation and Incident Report should have been done especially since it was mealtime. 44673 3. Resident #92 was admitted with the following but not limited to dementia, history of falling and depression. The 3/20/23 Physician Order documented transfer with mechanical lift. The 3/31/23 Comprehensive Care Plan for Activities of Daily Living documented total dependence/ two persons for assistance using mechanical lift for transfers. The 8/17/23 Quarterly Minimum Data Set documented Resident #92 had severely impaired cognition and was totally dependent on two staff members for transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 8/23 Nursing Aide Care Guide documented Resident #92 required total assistance for transferring with two staff using a mechanical lift. The 8/25/23 at 5:45 AM progress note documented Resident #92 was heard screaming in their room and Certified Nurse Aide #13 was in the room. The resident stated Certified Nurse Aide #13 picked them up and threw them in the chair and it hurt their finger. The 8/26/23 Radiology Report documented left hand fracture of a small bone in the wrist. The 8/28/23 Physician note documented resident had trauma to the left wrist. X-ray revealed a fracture of the left wrist. The 9/1/23 Investigation Summary completed by former Director of Nursing #12 documented Certified Nurse Aide # 13 stated they did not use the mechanical lift to transfer Resident #92 because they were small enough to stand and pivot. They further stated they did not hit the resident's hand. After reviewing all statements and the x-ray, it was determined there was reasonable cause that neglect occurred because it was a direct care plan violation. Certified Nurse Aide #13 was immediately removed from working at the facility and the agency was notified. During an observation on 10/18/24 at 8:45 AM Resident #92 was in the dining room holding a cup of orange juice in the left hand. The left hand had no swelling no redness and had good range of motion. At 12:30 PM Resident #92 was using the left hand to feed themselves chicken. During an interview on 10/21/24 at 10:00 AM Certified Nurse Aide #13 stated they did not remember the incident. They stated they would never intentionally hurt a resident. They stated they get report from the off going staff when they arrive at work, and they had access to the facility electronic health record. They stated they follow the resident plan of care. During an interview on 10/18/24 at 3:00 PM the former Director of Nursing Staff #12 stated Certified Nurse Aide #13 was from the staffing agency. They stated Resident #92 required a two person assist with a mechanical lift and Certified Nurse Aide #13 did not follow the care plan. They stated resident care directives were in the care plan and in the certified nurse aide Kardex (care instructions). 10 NYCRR 415.12 (h)(1)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 43478 Based on record reviews and interviews during the recertification and abbreviated (351312) surveys from 10/16/24 to 10/23/24, the facility did not ensure that Certified Nurse Aide performance appraisals were completed at least once every 12 months. Specifically, performance appraisals were not documented every 12 months for 4 of 5 Certified Nurse Aides (Certified Nurse Aides #1, #2, #3, #4) records reviewed. The findings are: There was no documented evidence that an annual performance review was completed for Certified Nurse Aide #1 who was hired 8/22/2018, Certified Nurse Aide #2 who was hired 7/20/2023, Certified Nurse Aide #3 who was hired 9/16/2020 and Certified Nurse Aide #4 who was hired 6/22/2023. On 10/17/24 at 4:08 PM during an interview with the Director of Human Resources, the surveyor requested to view the annual performance reviews for Certified Nurse Aides #1, #2, #3, #4, and #5. The Director of Human Resources stated they could not locate the annual performance reviews for Certified Nurse Aides #1, #2, #3, and #4. They stated the process for the annual performance review is that they give the annual performance review forms to the staff member and their supervisor based on hire date, and the form should be filled out within a week and should be returned to the Director of Human Resources, and they give the forms to the Administrator. 10 NYCRR 415.26 (c)(2)(iii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43478 Based on observations, record review, and interviews during the recertification and abbreviated (NY00351312) surveys from 10/16/24 to 10/23/24, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infection. Specifically, 1) the facility did not properly implement transmission-based precautions for 3 of 3 residents reviewed for infection control precautions (Residents #84, #117, #120) and 2) the facility did not ensure that an infection surveillance plan was implemented for identifying, tracking, and monitoring infections, communicable diseases, and outbreaks for 3 of 5 residents reviewed for infection control (Residents #122, #72, #120). The findings are: The facility policy, Infection Prevention and Control, Surveillance Program pp 125-127 documented the purpose of the Surveillance Program is to conduct surveillance of resident and employee infections to guide prevention activities and the Infection Preventionist conducts surveillance of infections among residents and employees by review of data. Data collection includes infection discovery/ diagnosis reports completed by each unit per resident infection and forwarded to the ICP upon discovery, all new infections will be logged on the ongoing infection control log. The facility policy, Infection Prevention and Control, Outbreak Control pp 141-157 documented that outbreak is defined as two or more cases over the usual endemic number of cases of healthcare associated infections or greater than 5% of the facility census usually produced by the same organism, and COVID: a single confirmed case (not present on admission) of staff or resident. Implement immediate control if an outbreak is confirmed included to initiate CDC guidelines for isolation/ precautions. The facility email titled 'Isolation List' from the Infection Preventionist dated 10/18 2024 documented 13 residents were positive for COVID-19 and 2 resident's roommates were positive for COVID-19. It documented Resident #120 was positive for COVID-19 (day 10 of 10) and Resident #117 was the roommate of a resident positive for COVID-19 (day 3 of 10). 1. On 10/17/24 at 11:03 AM, an observation was conducted on the 2nd floor unit. A bag of Personal Protective Equipment was observed hanging on Resident #84's door and a Contact Precautions sign was observed. Certified Nurse Aide #6 was pushing a mechanical lift out of the resident's room and Certified Nurse Aide #7 was inside the resident's room. Neither of the Certified Nurse Aides were observed wearing gowns. When asked at the time of the observation, both Certified Nurse Aides #6 and #7 stated they forgot to wear gowns and stated they realized that they should have worn gowns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/24 at 11:32 AM during an interview, Registered Nurse #9 stated that Resident #84 was on Droplet Precautions for Vancomycin Resistant Enterococcus (bacteria) in the urine and Colostrum Difficile (bacteria) in the stool, and the resident had a urinary catheter. They stated that all residents with a urinary catheter should be on Enhanced Barrier Precautions which would involve wearing gloves and gown. During a review of Resident #84's physician orders with Registered Nurse #9, Droplet Precautions for VRE in urine and C-Diff was documented, but no order could be located for Enhanced Barrier or Contact Precautions. During an observation of Resident #84's room door with Registered Nurse #9, the sign observed posted on the door documented Contact Precaution, wear gown and gloves. Registered Nurse #9 stated that Resident #84 should have physician orders for Contact Precautions for the diagnoses of Vancomycin Resistant Enterococcus in the urine and Colostrum Difficile in the stool, and Enhanced Barrier Precautions for the presence of a urinary catheter. On 10/22/24 at 11:37 AM during an interview, Licensed Practical Nurse #11 stated that for Resident #84, staff providing direct care such as assisting with transfers should be wearing gown and gloves and mask. These items were required for diagnoses of Vancomycin Resistant Enterococcus bacteria in the urine and Colostrum Difficile bacteria in the stool, and the presence of a urinary catheter. On 10/22/24 at 3:42 PM during an interview, the Infection Preventionist stated that Resident #84 should be on Enhanced Barrier Precautions for the presence of a urinary catheter, and they should be on Contact Precautions for their diagnoses of Vancomycin Resistant Enterococcus in the urine and Colostrum Difficile in the stool. During a review of Resident #84's physician orders they stated that Enhanced Barrier Precautions and Contact Precautions should have been ordered on 9/27/24 but were not ordered until 10/22/24. On 10/16/24 at 10:18 AM and on 10/18/24 at 9:43 AM, Resident #117 was observed sitting in the hallway in their wheelchair in front of the nursing station with their mask below their chin. On 10/18/24 at 9:47 AM, Resident #120's room door was observed with a sign for Droplet Precaution. On 10/18/24 at 11:23 AM during an interview, Registered Nurse Unit Manager #26 stated that Resident #117 was exposed to COVID -19, and they did not believe Resident #117 should be sitting in the hallway without a mask covering their mouth and nose and stated they should have clarified with Infection Preventionist. Registered Nurse Unit Manager #26 further stated that Resident #120 was positive for COVID-19. They stated the Droplet Precaution sign on the door was for COVID-19, but stated staff should also wear a gown so they should also be on Contact Precautions. Registered Nurse Unit Manager #26 stated they had not had a COVID-19 in-service at the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 at 3:42 PM during an interview, the Infection Preventionist stated that residents who were exposed to COVID-19 should wear a mask when out of the room and the order should be for Standard Precautions. During a review of Resident #120's medical record with the Infection Preventionist, it documented that Resident #120 was positive for COVID-19 on 10/9/24. The Infection Preventionist stated that no order was placed for Contact Precautions. The Infection Preventionist stated that residents who are positive for COVID-19 should have orders in place for Droplet & Contact Precautions. The Infection Preventionist stated that the nurse performing the admission assessment should enter the orders for the appropriate precautions, and stated there is a list of infections and appropriate precautions in the infection control manual and in the shared folder in the computers to which all staff has access. The Infection Preventionist stated that the nurse who enters the precaution orders is responsible to delegate a staff member to place the appropriate sign on the resident's door. They stated they are aware that unit staff has exhibited problems with understanding the precautions to be ordered, the proper personal protective equipment to be worn, and the proper precautions signs to be posted on resident's doors. 2. On 10/18/24 at 12:00 PM during an interview with the Infection Preventionist, a review of the facility infection tracking logs was conducted. The infection tracking logs did not document a complete list of resident infections for the month of October 2024 and there was no infection tracking log for the month of August 2024 that could be reviewed for infection onset dates, signs and symptoms, lab tests/results, isolation, and outbreak potential. During a review of Resident #122's medical record with the Infection Preventionist, they stated Resident #122 had symptoms of cloudy urine on 10/11/24 and started an antibiotic Zosyn on 10/14/24 for cystitis (bladder inflammation caused by infection). They stated Resident #122 should have been entered onto infection tracking log on 10/11/24 but was not. During a review of Resident #72's medical record with the Infection Preventionist, they stated Resident #72 had symptoms of dysuria (pain on urination) on 10/1/24 and started on an antibiotic Macrodantin on 10/8/24 for urinary tract infection, then antibiotic Zosyn for a urinary tract infection on 10/9/24. They stated Resident #72 should have been entered on the infection tracking log on 10/1/24 but was not. During a review of Resident #120's medical record with the Infection Preventionist, they stated Resident #120 had symptoms of Gastritis (stomach upset) and suspected urinary tract infection on 8/21/24 and started on antibiotic Bactrim for cystitis on 8/26/24. They stated that Resident #120 should have been entered on the infection tracking log on 8/21/24 but was not. The Infection Preventionist stated the Unit Manager or Nursing Supervisor was responsible to report any change in condition on the unit, and the Director of Nursing was responsible to assure it was being done. The Infection Preventionist stated that the infection tracking logs should be used to track infections in the building to assure that residents were protected from exposure to residents with infections and to prevent the spread of infections. The Infection Preventionist further stated they had not started an infection tracking log until September 2024. On 10/22/24 at 11:28 AM during an interview, the Administrator stated that residents should be documented on the infection tracking log upon discovery in real time. 10NYCRR 415.19(a)(2)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 49255 Based on observations, interviews and record reviews conducted during the recertification and abbreviated (NY00351312) surveys from 10/16/24 to 10/23/24 the facility did not maintain an effective pest control program so that the facility was free of pests. Specifically, Resident #70's room had glue traps for insects and rodents, with gnats and cockroaches observed inside the trap. Findings include: The facility policy and procedure titled Pest Control with a revised date of May 2008 documented the facility maintained an on-going pest control program to ensure that the building was kept free of insects and rodents. During observation on 10/16/24 at 10:38 AM, Resident #70's room had insect and rodent traps on the cabinet next to the resident's bed, and on the sink counter, with many gnats and a cockroach stuck inside the trap. During an interview on 10/16/24 at 12:05 PM, Resident #70 stated that in their room they had flies and roaches on a regular basis and that was why there were traps. The resident stated they had lived at the facility for over 3 years and the pest problem had remained an issue. Review of the Pest Logbook dated 2022 to 2024, documented the presence of cockroaches noted by the staff in different areas of the facility. Review detailed service reports from 2 pest control companies for 2024, documented pest services were provided by both companies. Review of the Company B's exterminator summary of service on 9/11/24 documented they found 2 bed bugs in unit 211. Company B's Summary of Services for September 2024 and October 2024 documented infestation with cockroaches on 1st and 2nd floors dining hall, lounge, and kitchen areas. During an interview on 10/18/24 at 9:56 AM, Certified Nurse Aide #21 stated they observed roaches mostly in residents' bathrooms and dining area. They stated the last time they noticed the presence of roaches was in September of this year. During an interview on 10/18/24 at 12:22 PM, the Director of Housekeeping stated that all problems with roaches existed since 2023, and 2024 was the worst year. The pest control provided services, but they were not effective and the situation got worse from 2023 to 2024. The past control technician went from room to room, but this intervention did not help to resolve the problem. During an interview on 10/18/24 at 12:24 PM, the Administrator stated they had reports from the staff about the presence of roaches during 2023 and 2024. The Administrator showed the Pest Log Book from 2022 to 2024 with documentation about the presence of roaches. They stated they had used Company A, who provided pest control services in 2023 and 2024. They stated when Company A could not resolve the issue with roaches, they canceled services with them in August 2024. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/18/24 at 12:41 PM, the Maintenance Director stated they started working with the new pest control company (Company B) a few months ago and the situation with roaches was better. The new company provided a better treatment than the previous company. The Maintenance Director stated they were following the recommendations that the pest company suggested. 10 NYCRR 415.29(j)(5)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 44673 Based on record review and interview during a recertification survey and abbreviated survey (NY 00322762), the facility did not ensure staff were provided with education on activities that constitute abuse, neglect, exploitation, dementia management and misappropriation of resident property for 1 of 6 staff members reviewed (Certified Nurse Aide #13) for education. Specifically, the facility was unable to provide documented evidence Certified Nurse Aide #13 received any education. Findings include: The 3/08 Policy titled Abuse Prevention Reporting and Investigating documented all employees receive education related to abuse, neglect and misappropriation of resident property, involuntary seclusion, and abandonment. The 9/1/23 Investigation Summary completed by former Director of Nursing #12 documented Resident #92 sustained a wrist fracture. The evidence including statements and an x-ray determined that there was reasonable cause that neglect had occurred and it was a direct care plan violation by Certified Nurse Aide #13. Certified Nurse Aide #13 was immediately removed from working at the facility and the staffing agency was notified. On 10/18/24 at 10:00 AM, education on abuse, dementia, and misappropriation of resident property for Certified Nurse Aide #13 was requested from the Administrator. The Administrator was not able to provide the documentation. On 10/18/24 at 10:30 AM, education on abuse, dementia, and misappropriation of resident property for Certified Nurse Aide #13 was requested from the staffing agency. The staffing agency was not able to provide the documentation. During a interview on 10/18/24 at 3:00 PM, former Director of Nursing #12 stated Certified Nurse Aide #13 was from a staffing agency and the agency was responsible for providing the education. During a 10/21/24 at 10:00 AM telephone interview Certified Nurse Aide #13 stated they had education in dementia care, abuse and misappropriation of property. They stated the documentation was unavailable. During a 10/21/24 at 10:15 AM interview the Account Manager from the staffing agency stated that staff picked up shifts and they were independent contractors. The agency Account Manager stated it was up to Certified Nurse Aide #13 if they want the education. They reviewed Certified Nurse Aide #13's records and stated it did not look like they did the education. During an interview on 10/21/24 at 10:30 AM, the Administrator stated the incident occurred with the former Administrator and Certified Nurse Aide #13 did not have in-service on abuse, dementia, and misappropriation of property on file. 10 NYCRR 415.12 (h) (2)